Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Charles Xeller, MD

Respondent Name
American Zurich Insurance Company

MFDR Tracking Number
M4-14-3786-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
August 29, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "No response to reconsideration"

Amount in Dispute: $350.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The bill in question was escalated and the review has been finalized. Our bill audit Company has determined no further payment is due. Please see below for the rationale behind their denial:

DOS: The provider's State Billing License Number is invalid or was not received pursuant to Texas Rule 133.10"

Response Submitted by: Gallagher Bassett Services, Inc., 11940 Jollyville Rd, Suite 210-N, Austin, TX 78759

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 24, 2014	Designated Doctor's Exam to Determine Maximum Medical Improvement and Impairment Rating	$350.00	$350.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133. 10 (f)(1) defines the required elements to be included on the CMS-1500 for professional services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 16 – (16) Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.

Issues

1. Did the requestor provide the necessary license information when billing for the examination to determine Maximum Medical Improvement and Impairment Rating?
2. What is the correct reimbursement amount for the examination in question?

3. Is the requestor entitled to additional reimbursement?

Findings

1. Per 28 Texas Administrative Code §133.10 (f)(1), "The following data content or data elements are required for a complete professional or noninstitutional medical bill related to Texas workers' compensation health care: …(U) rendering provider's state license number (CMS-1500/field 24j, shaded portion) is required when the rendering provider is not the billing provider listed in CMS-1500/field 33; the billing provider shall enter the '0B' qualifier and the license type, license number, and jurisdiction code (for example, 'MDF1234TX'); … (Z) signature of physician or supplier, the degrees or credentials, and the date (CMS-1500/field 31) is required, but the signature may be represented with a notation that the signature is on file and the typed name of the physician or supplier; … (EE) billing provider's state license number (CMS-1500/field 33b) is required when the billing provider has a state license number; the billing provider shall enter the '0B' qualifier and the license type, license number, and jurisdiction code (for example, 'MDF1234TX')."

   A review of the submitted documentation finds that on both the original bill and on the request for reconsideration, the rendering provider's license number was included in the appropriate location at CMS-1500/field 24j (shaded portion). The Texas Medical Board website confirms the provided license number to be valid for Charles Xeller, MD, who is listed as the rendering provider on the CMS-1500. No license number is required in CMS-1500/field 31 for the rendering provider, but this field correctly contains the provider's degree (MD) and credentials (Orthopaedic Surgery). The license number is only required in CMS-1500/field 33b if the billing provider has a state license number. Pacific Billing Services, Inc. does not have a medical license number, so none is required.

   The Division finds that the requestor provided the necessary license information when billing for the examination to determine Maximum Medical Improvement and Impairment Rating and is, therefore, eligible for reimbursement.
2. Per 28 Texas Administrative Code §134.204 (j)(2), "(A) If the examining doctor, other than the treating doctor, determines MMI has not been reached, the MMI evaluation portion of the examination shall be billed and reimbursed in accordance with paragraph (3) of this subsection. Modifier "NM" shall be added. (B) If the examining doctor determines MMI has been reached and there is no permanent impairment because the injury was sufficiently minor, an IR evaluation is not warranted and only the MMI evaluation portion of the examination shall be billed and reimbursed in accordance with paragraph (3) of this subsection."

   Per 28 Texas Administrative Code §134.204 (j)(3), "The following applies for billing and reimbursement of an MMI evaluation. (C) An examining doctor, other than the treating doctor, shall bill using CPT Code 99456. Reimbursement shall be $350."
3. Review of the submitted documentation finds that the requestor billed for this examination using CPT Code 99456 with modifier 'NM', indicating that the examinee had not reached Maximum Medical Improvement. Therefore, the correct reimbursement amount for this examination is $350.00. The requestor billed $650.00. The Explanations of Benefits provided indicate the insurance carrier has reimbursed $0.00. The Division finds that the requestor is entitled to an additional $350.00.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $350.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $350.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Laurie Garnes Medical Fee Dispute Resolution Officer	December 18, 2014 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.